STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain dignity and respect for two residents (#100, #213) of forty-four sampled residents. The findings included: Resident #100 was admitted to the facility on May 17, 2011, and readmitted on May 1, 2013, with diagnoses including Amputation Left Toe, Dementia, Anxiety, and Decubitus Ulcer Left Heel. Medical record review of a quarterly Minimum Data Set (MDS) dated April 10, 2013, revealed the resident was totally dependent for dressing. Observation on May 13, 2013, at 1:00 p.m., in the resident's room, revealed the resident lying on the bed and dressed in a hospital gown. Observation on May 14, 2013, at 3:45 p.m., in the resident's room, revealed the resident lying on the back and dressed in a hospital gown. Observation on May 15, 2013, at 8:05 a.m., revealed the resident awake, lying in the bed with a clothing protector in place, and dressed in a	F 241	This Plan of Correction constitutes our credible allegation of compliance. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F241 1. Corrective action Director of Nursing removed signage from doorframe of resident #213 immediately on 05/15/13. CNA assigned to resident #100 offered to change to loose fitting clothing and resident chose not to change on 05/14/13. 2. Identification Director of Nursing removed signage from all other doorframes on 05/15/13. No other residents who wear facility provided gowns were found to be affected.	7/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 6/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 hospital gown. Interview with Licensed Practical Nurse (LPN) #2 on May 15, 2013, at 8:24 a.m., at the 100 hall Nurse's Station, confirmed the resident was to be dressed in loose personal clothes. Resident #213 was admitted to the facility on May 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airway Obstruction, Urinary Tract Infection, and Anxiety. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented. Observation on May 13, 2013, at 12:11 p.m., outside the resident's room, revealed a sign posted "please have pt (patient) in...up in W/C (wheelchair) by 11:00 am daily m-f (Monday-Friday) for therapy thank you." Interview with the Director of Nursing on May 15, 2013, at 2:37 p.m., in the Unit Manager's Office, confirmed the sign on the resident's door failed to respect the resident's dignity and individuality.	F 241	3. Measures Therapy manager, Restorative manager, and Director of Nursing were inserviced by staff development coordinator on 05/15/13 regarding signage and acceptable locations for individual patient information. Staff Development Coordinator provided inservice to staff regarding provision of choices to residents on wearing facility provided gowns on 05/15/13. The Unit Coordinators will conduct signage and gown audits weekly for 4 weeks then monthly for 2 months to ensure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for	7/1/13
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		

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F 242	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure staff honored the resident's preferences for getting out of the bed for one resident (#201) of forty-four residents reviewed. The findings included: Resident #201 was admitted to the facility on February 27, 2013, with diagnoses including Dementia, Muscle Weakness, Dysphagia, Depressive Disorder, and Difficulty Walking. Medical record review of the admission Minimum Data Set (MDS) dated March 6, 2013, revealed the resident required extensive assistance for transfers and locomotion. Medical record review of the resident's care plan last updated on April 1, 2013, revealed "...use questions that can be answered yes or no..." Observation on May 13, 2013, at 11:30 a.m. and 4:45 p.m., revealed the resident lying in bed. Observation on May 14, 2013, at 7:42 a.m., revealed the resident lying in bed. Observation on May 15, 2013, at 9:35 a.m., 10:42 a.m., and 11:40 a.m., revealed the resident lying in the bed. Interview with the resident, in the resident's room, on May 15, 2013, at 9:35 a.m., revealed the resident wanted to get out of bed. When interviewed related to if staff gets resident out of	F 242	3 months or until 100% compliance is achieved. The Executive Director will monitor to assure continued compliance.	7/1/13

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F 242	Continued From page 3 bed the resident replied "no." Interview with Certified Nursing Assistant (CNA) #1 on May 15, 2013, at 9:35 a.m., outside the resident's room, revealed the resident can communicate his/her needs to the staff. Interview with Licensed Practical Nurse (LPN) #1 on May 15, 2013, at 11:35 a.m., revealed the resident "can answer yes or no questions." LPN #1 then asked the resident if "has been out of bed during the past few days," the resident replied "no." LPN #1 asked the resident if "wants to get up" and the resident replied "yes." Continued interview revealed the resident's preference to be out of bed was not honored.	F 242	F242 1. Corrective action Resident #201 was immediately placed in her Geri-chair by CNA on 05/15/13 2. Identifying other residents Residents remaining in bed were asked if they wanted to get out of bed by Unit Coordinators on 05/15/13 3. Measures Nursing staff inserviced on 05/15/13 by Staff Development coordinator related to resident's choices and patient centered care. The Unit Coordinators will conduct audits regarding resident choice to get out of bed or not, weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accommodate the needs for two residents (#213, #103) of forty-four sampled residents. The findings included: Resident #213 was admitted to the facility on May	F 246		7/1/13

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F 246	Continued From page 4 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airway Obstruction, Urinary Tract Infection, and Anxiety. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented, used hand gestures to communicate, and was partially deaf. Observation and interview with resident #213 on May 15, 2013, at 3:00 p.m., in the resident's room, revealed the resident sitting on the side of the bed. The resident was concerned regarding a family member and was unable to use the facility phone due to the resident was deaf. Further interview revealed the resident had a phone at the resident's house the resident could use to hear conversations. Interview with the facility Social Worker on May 15, at 3:12 p.m., revealed the facility was aware the resident was unable to communicate on the facility phone due to the partial deafness. Further interview confirmed the facility failed to provide the resident a phone to accommodate the resident's deafness. Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Hemiplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the resident lying in bed with the feet hanging over the foot of the bed.	F 246	F246 1. Corrective action The Social Services Director provided Resident # 213 with telephone amplifier on 05/16/13 and resident chose not to use the device. Resident #103 bed was extendable and was adjusted on 05/15/13 by Maintenance Supervisor 2. Identifying other residents Residents with hearing impairment were reviewed by social services on 05/16/13 to assure accommodation of needs with regard to amplified telephones. 100% audit completed by nursing management by observation on the beds on 05/16/13 to assure they are the proper size for each patient 3. Measures Staff inserviced on 05/16/13 by Staff Development Coordinator to assure identification of patients requiring amplified telephones and proper bed size. Admissions nurse, Social Services Director and Social Services assistant were inserviced on 05/21/13 by the Unit Coordinator to assure residents with hearing impairment are assessed for the need for an amplified telephone on admission. The Social Services Director will complete audit of residents for the need for amplified telephones weekly for 4 weeks, then monthly for 2 months and submit the results to the Director of Nursing.	7/1/13

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F 246	Continued From page 5 Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed. Review of the quarterly Minimum Data Set (MDS) dated February 6, 2013, revealed the resident's height was 75 inches (6 feet 3 inches). Interview with the resident on May 15, 2013, at 8:35 a.m.; in the resident's room revealed, "I hope I can get a long mattress." Interview with Maintenance Workers #1 and #2 on May 15, 2013, at 8:38 a.m., in the resident's room, revealed the foot board would only be off the bed if the resident is too tall and "we try to not take the foot boards off the beds; we do have some long mattresses, and we also have extensions for the mattresses. The foot boards can be extended four inches." Interview with Certified Nursing Assistant #3 on May 15, 2013, at 8:45 a.m., in the resident's room, revealed the resident's feet hang off the bed due to (the resident) is tall. Interview with Registered Nurse (RN) #3 on May 15, 2013, at 8:43 a.m., in the resident's room, confirmed the foot board was missing, the resident needs a long mattress, and RN #3 would check on getting the resident a mattress to accommodate the resident height.	F 246	4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	F279 1. Corrective action Resident #213 care plan was revised on 05/16/13 by MDS Coordinator to include hearing impairment. Resident #213 care plan was revised on 05/16/13 by MDS Coordinator to include dental concerns. Resident #80 care plan was revised on 05/16/13 by MDS Coordinator to include fall risk.	7/1/13

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F 279	Continued From page 6 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for two residents (#213, #80) of twenty-nine residents reviewed of forty-four sampled residents. The findings included: Resident #213 was admitted to the facility on May 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airway Obstruction, Urinary Tract Infection, and Anxiety. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented, had loose/missing teeth, used hand gestures to	F 279	2. Identification Resident care plans reviewed on 05/15/13 by nursing management team to assure hearing impairments, fall risks, and dental services are properly addressed on admission or with a significant change. 3. Measures Staff development coordinator completed inservice with nursing management team on 05/17/13 regarding review of care plans to include hearing impairments, fall risks, and dental concerns on admission, with a significant change, quarterly with care plan review, and annually with care plan review. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee,	7/1/13

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F 279	Continued From page 7 communicate, and was partially deaf. Medical record review of the Interim Care Plan dated May 2, 2013, revealed the care plan did not address the resident's dental or communication needs. Interview with the Licensed Practical Nurse (LPN) #3 on May 15, 2013, at 3:00 p.m., in the Assistant Director of Nursing Office, revealed LPN #3 completed the Interim Care Plan. Continued interview confirmed the facility failed to develop an Interim Care Plan to include the loose/missing teeth and the resident's communication needs related to the diagnosis of partially Deaf. Resident #80 was admitted to the facility on February 12, 2013, with diagnoses including Pneumonia, Decubitus Ulcer, Paralysis, and Diabetes Mellitus. Medical record review of a fall risk score dated February 12, 2013, revealed a score of fourteen indicating resident was a high fall risk. Continued medical record review of the resident's current plan of care revealed the care plan did not address the fall risk. Interview on May 14, 2013, at 4:04 p.m., at the 100 hall nurse's station, with Licensed Practical Nurse (LPN) #2 confirmed the care plan did not address falls.	F 279	additional education may be provided: the process evaluated revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance. F281 1. Corrective action Admissions nurse corrected Resident # 212 Vitamin D order Med Pass dietary supplement on current medication administration record on 05/13/13. Unit Manager on 05/13/13 notified Medical Doctor with no new orders. 2. Identification The nursing management team completed audit on 05/13/13 to assure orders correctly transcribed upon receipt. Audit completed of orders received in the facility for the period of 04/18/13 to 05/01/13.	7/1/13
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to follow the physician's orders for one resident (#212) of forty-four residents reviewed. The findings included: Resident #212 was admitted to the facility on April 18, 2013, with diagnoses including Hip Fracture, Coronary Artery Disease, Osteoporosis, and Malnutrition. Medical record review of a physician's order dated April 24, 2013, revealed "...Vit (vitamin) D 1000 units PO (by mouth) daily...Med Pass 2.0 (nutritional supplement) 4 oz (ounce) PO TID (three times daily)..." Medical record review of a physician's recapitulation (recap) orders for May 1, 2013, through May 31, 2013, revealed the Vitamin D and the Med Pass were not listed. Medical record review of a Medication Administration Record (MAR) for May 1, 2013, through May 31, 2013, revealed the Vitamin D and the Med Pass had not been given as prescribed from May 1, 2013 through May 13, 2013. Interview with Licensed Practical Nurse (LPN) #2 on May 13, 2013, at 3:12 p.m., in the southwest nurses' station, confirmed the Vitamin D and the Med Pass were not listed on the May physician's recap orders and had not been given.	F 281	3. Measures Staff Development Coordinator completed inservice on transcription of orders. Unit Coordinators will complete audits of orders received last 10 days of each month to assure accurate transcription. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the medical director, executive directive, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review the results if deemed necessary by the committee, additional education may be provided: the process evaluated revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		7/1/13

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F 309 SS=D	Continued From page 9 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to ensure a mattress was of the appropriate size for one resident (#103) of forty-four residents reviewed. The findings included: Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Hemiplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the resident lying in bed with the feet hanging over the foot of the bed. Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed. Review of the quarterly Minimum Data Set (MDS) dated February 6, 2013, revealed the resident's height was 75 inches (6 feet 3 inches).	F 309	F309 1. Corrective action Resident #103 bed was extendable and was adjusted on 05/15/13 by Maintenance Supervisor. 2. Identification of residents 100% audit completed by nursing management by observation on the beds on 05/16/13 to assure they are the proper size for each patient. 3. Measures Staff Development Coordinator completed inservice for admissions nurse and Treatment Nurse regarding proper bed size and reporting system if bed is deemed to be incorrect size for patient. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week.	7/1/13

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F 309	Continued From page 10 Interview with the resident on May 15, 2013, at 8:35 a.m., in the resident's room revealed, "I hope I can get a long mattress." Interview with Maintenance Workers #1 and #2 on May 15, 2013, at 8:38 a.m., in the resident's room, revealed the foot board would only be off the bed if the resident is too tall and "we try to not take the foot boards off the beds; we do have some long mattresses, and we also have extensions for the mattresses. The foot boards can be extended four inches." Interview with Certified Nursing Assistant #3 on May 15, 2013, at 8:45 a.m., in the resident's room, revealed the resident's feet hang off the bed due to (the resident) is tall. Interview with Registered Nurse (RN) #3 on May 15, 2013, at 8:43 a.m., in the resident's room, confirmed the foot board was missing, the resident needs a long mattress, and RN #3 would check on getting the resident a mattress to accommodate the resident height.	F 309	4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	7/1/13
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate	F 322		

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	445240	A. BUILDING _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

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F 322	Continued From page 11 treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure tube feedings were properly labeled for one resident (#35) and failed to check placement of a feeding tube prior to administration of medications and feedings for one resident (#209) of forty-four sampled residents. The findings included: Resident #35 was admitted to the facility on April 27, 2013, with diagnoses including Venous Insufficiency, Pneumonia, Decubitus, Dementia, Chronic Obstructive Pulmonary Disease, Hemiplegia, Malnutrition, Depressive Disorder, Muscle Weakness, and Gastrostomy. Observation on May 13, 2013, at 3:08 p.m., revealed the resident lying in the bed with Pulmocare (therapeutic nutrition for pulmonary patients) infusing at 50 milliliters (ml) per hour per	F 322	322 1. Corrective action The nurse immediately replaced tube-feeding formula on resident #35 on 05/13/13, the tube feeding placement was checked immediately by Staff Development coordinator on resident #209 on 05/13/13 and found to be correctly placed. 2. Identification of residents Audit of all tube feeding was completed on 05/13/13 by nursing managers to assure all containers were labeled correctly with both date and time.	7/1/13

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F 322	Continued From page 12 the Percutaneuous Endoscopic Gastrostomy (PEG) feeding tube and it did not have a start time on the bottle. Review of facility policy, Nasogastric/Gastrostomy Tube Feeding, revised May 21, 2004, revealed "...label the feeding bag with...name, room, date, and time started..." Interview with Licensed Practical Nurse #1 on May 13, 2013, at 3:08 p.m., in the resident's room, confirmed "it should be timed." Resident #209 was admitted to the facility on April 12, 2013, with diagnoses including Right Hip Fracture and Dysphagia. Observation of a medication administration with Licensed Practical Nurse (LPN) #5 on May 13, 2013, at 4:48 p.m., revealed the LPN entered resident #209's room to administer Coumadin (blood thinner), Pepcid (histamine), and one 8 ounce can of Glucerna 1.5. Continued observation revealed the resident had a Gastrostomy Tube (feeding tube inserted in the stomach). Observation and interview with LPN #5 on May 13, 2013, at 5:00 p.m., confirmed "I usually verify placement before giving anything in the tube but I do not have a stethoscope and there is not one on my cart." Further observation revealed the LPN administered one can of Glucerna 1.5, Pepcid, and Coumadin without checking the tube placement. Facility policy review Enteral Nutritional Therapy (Tube Feeding) last revised May 21, 2004,	F 322	3. Measures Staff Development Coordinator inservice for all nurses on 05/16/13 regarding correctly dating, timing, and signing all enteral formulas when they are hung for patient use. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated, revised and or the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to assure continued compliance.	7/1/13

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F 322	Continued From page 13 revealed " ...4. Check position of tubing ...6. Administer the amount of feeding to be given ..." Interview with Registered Nurse #2 on May 13, 2013, at 5:05 p.m., in the south hallway, confirmed the tube check placement was to be performed prior to administering enteral feedings and/or medications.	F 322		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen in a clean and sanitary condition. The findings included: Observation with the Dietary Manager on May 13, 2013, at 9:40 a.m., revealed there was no hand wash station other than the food preparation sink. Continued observation revealed there was food items on the food preparation sink in which staff were using as the same sink to wash soiled hands. Further observation revealed an ice machine located in the kitchen area with a drain	F 371	F371 1. Corrective Action Hand washing sink was installed on May 30, 2013. The ice machine drain was immediately connected during the inspection. 2. Identification All other sinks and ice machine drains were inspected by the maintenance staff. 3. Measurement Dietary manager will observe ice machine drain daily for proper placement and will notify maintenance department if drain is not in working order. Dietary director will notify administrator weekly if any problems have been noted.	7/1/13

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F 371	Continued From page 14 and visible green tinge coming out from the ice machine, touching a drain in the floor. Interview with the Dietary Manager on May 13, 2013, at 9:58 a.m., in the kitchen, confirmed the hand wash sink had been removed and the ice machine drainage pipe was not elevated to prevent sewage backslash into the ice drain pipe. Continued interview confirmed the facility failed to ensure a sanitary environment in the kitchen.	F 371	4. Monitoring The Administrator will submit the results of the observations to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provided dental services to one resident (#213) of forty-four sampled residents. The findings included:	F 411	F411 1. Corrective action The Social Services Director referred Resident #213 for dental services immediately on 05/15/13. The Resident chose to refuse dental services on 05/16/13. 2. .Identification Audit of dental assessments was completed on 05/20/13 by nursing management to determine that residents were receiving services as needed.	7/1/13

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F 411	Continued From page 15 Resident #213 was admitted to the facility on May 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airway Obstruction, Urinary Tract Infection, and Anxiety. Observation and interview with the resident on May 13, at 3:40 p.m., in the resident's room, revealed the resident sitting on the side of the bed. Continued observation revealed the resident had loose/missing teeth The resident revealed he/she would like to see a dentist and the facility had not offered dental services to the resident. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented and had loose/missing teeth. Interview with the facility Social Worker on May 15, 2013, at 3:00 p.m., in the Social Worker's office, revealed the dentist had visited the facility on May 14, 2013, and the resident was not on the list to be seen by the dentist. Continued interview confirmed the resident was not offered dental services.	F 411	3. Measurement Staff Development Coordinator provided educational inservice on 05/17/13 regarding provision of services based on admission assessment indications. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure residents with dental needs are referred to Dentist. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		7/1/13

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F 431	Continued From page 16 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to store medications properly for one resident #38 of forty-four sampled residents. The findings included: Resident #38 was admitted to the facility on March 22, 2013, with diagnoses including Depressive Disorder, Chronic Obstructive Pulmonary Disease, Chronic Airway Obstruction, and Chronic Respiratory Failure.	F 431	F431 1. Corrective action Medication was discarded from the container in resident #38 room immediately by the nurse on 05/14/13. 2. Identification Audit completed of residents with Nebulizers was completed on 05/14/13 by the nursing management team to assure no nebulizer contained any residual medication. 3. Measurement Staff Development Coordinator provided inservice on medication storage with nurses on 05/17/13. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week.	7/1/13

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F 431	Continued From page 17 Medical record review of the Physician's recapitulation orders dated May 1, 2013, revealed the resident received "...Budesonide (medication for shortness of breath)...twice daily...via nebulizer..." Observation on May 14, 2013, at 8:21 a.m., with Licensed Practical Nurse (LPN) #4 revealed resident #38 sitting on the side of the bed eating breakfast. Continued observation revealed LPN #4 administered medications with the meal. Observation revealed the charge nurse told resident would return to give the Budesonide via nebulizer. The resident then stated there was already a medication left in the nebulizer ready to be given that had been left in the room. Interview on May 14, 2013, at 8:29 a.m., with LPN #4, outside the resident room confirmed the resident's medication was not to be left in the room.	F 431	4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 1. Corrective action The nurse for resident #62 and the CNA for # 96 were inserviced immediately with regard to handwashing by the Staff Development Coordinator on 05/13/13. Nurse instructed on use of barrier material immediately by Director of Nursing on 05/13/13. Nurse instructed on use of barrier material immediately by Director of Nursing on 05/13/13.	7/1/13

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F 441	Continued From page 18 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to maintain medications and medical equipment in a sanitary manner for two residents (#209, #63) and ensure staff washed hands after entering isolation rooms (#62, #96) of forty-three sampled residents. The findings included: Review of facility policy Hand Hygiene. Observation with Licensed Practical Nurse (LPN)	F 441	2. Identification Residents in the facility could be affected by hand sanitation and barrier use practices. 3. Measurement The Staff Development Coordinator conducted educational inservices to staff on 05/13/13 regarding handwashing and medical equipment handling. The Staff Development Coordinator and Unit Coordinators will conduct handwashing observation audit weekly for 4 weeks and monthly for 2 months to assure compliance and submit the results to the Director of Nursing. Hand sanitizer will be placed in the resident rooms by maintenance staff during the week of June 10, 2013 to ensure hand sanitation compliance. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be	7/1/13

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F 441	Continued From page 19 #5 on May 13, 2013, at 4:48 p.m., in resident #209's room, revealed the LPN entered the resident's bathroom, placed two 30ml (milliliter) medication cups containing Coumadin (blood thinner) and Pepcid (histamine) and a glucometer (used to perform blood sugars) on the bathroom sink, washed the hands, retrieved the medication cups and the glucometer, administered the medications, and checked the resident's blood sugar with the glucometer. Interview with LPN #5 on May 13, 2013, at 5:00 p.m., in the south hallway, revealed the sink had been "dirty". Continued interview confirmed the nurse failed to follow infection control standards. Observation with Registered Nurse (RN) #1 on May 14, 2013, at 5:12 p.m., in resident #63's room, revealed the RN entered the resident's bathroom, placed the individual prepackaged Refresh eye drops on the bathroom sink, washed the hands, retrieved the Refresh eye drops, applied gloves, and administered the eye drops to resident #63. Interview with RN #1 on May 14, 2013, at 5:15 p.m., in the hallway, revealed the sink had been "dirty". Continued interview confirmed the nurse failed to follow infection control standards. Observation on May 13, 2013, at 12:25 p.m., revealed Certified Nurse Aide (CNA) #2 entered resident #62's room identified as isolation, exited the room without washing the hands, and entered another resident's room. Review of a list of residents on contact isolation provided by the facility revealed resident #62 was	F 441	provided: the process evaluated, revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	7/1/13

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F 441	Continued From page 20 in contact isolation for a Multi-Drug Resistant Organism. Interview with CNA #2 on May 13, 2013, at 12:27 p.m., in the hallway, confirmed the CNA failed to wash the hands after entering a resident's room in contact isolation. Observation on May 13, 2013, at 10:00 a.m., revealed Licensed Practical Nurse (LPN) #4 entered resident #96's room to administer medications without gloved hands and then exited the room without washing the hands. Further observation revealed supplies for contact isolation hanging on the resident's room door. Interview with LPN #4 on May 13, 2013, at 10:05 a.m., outside the resident's room, confirmed the LPN failed to wash the hands before exiting the resident's room. Review of a list of residents on contact isolation provided by the facility revealed resident #96 was in contact isolation for a Multi-Drug Resistant Organism. Interview with LPN #2 on May 15, 2013, from 11:00 a.m. till 11:30 a.m., at the 200 nurse's station, confirmed the facility placed residents in contact isolation for Multi-Drug Resistant Organisms in the urine to indicate to staff and visitors the importance of diligent hand washing after contact with the residents to prevent the spread of Multi-Drug Resistant Organisms.	F 441		7/1/13

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